Avera Health Plans

The Consumer's Guide for Individual Plans

Discrimination is Against the Law

Avera Health Plans complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Avera Health Plans does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Avera Health Plans

- Provides free aids and services to people with disabilities to communicate effectively with us, such as: qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as: qualified interpreters and information written in other languages.

If you need these services, contact the Avera Health Plans Customer Care team at 1-888-322-2115, (TTY 711), 8 a.m. to 5 p.m. CST, Monday through Friday.

If you believe that DAKOTACARE/DAS has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance with:

Complaint and Appeals Coordinator
Avera Health Plans
5300 S Broadband Ln
Sioux Falls, SD 57108-2221

Fax 1-800-269-8561
Email ComplaintAppeals@AveraHealthPlans.com

You can file a grievance in person or by mail, fax, or email. You may also contact the Complaint and Appeals Coordinator if you need assistance with filing a complaint.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or call 1-800-368-1019 or 1-800-537-7697 (TDD). Or mail:

US Department of Health and Human Services,
200 Independence Avenue SW Room 509F, HHH Building,
Washington, D.C. 20201

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Getting Help in Other Languages

Language assistance services are available free of charge. Our Customer Care team is available 8 a.m. to 5 p.m. CST, Monday – Friday, toll-free at 1-888-322-2115 (TTY: 1-800-877-1113).

- ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-322-2115 (TTY: 1-800-877-1113).
- LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-888-322-2115 (TTY: 1-800-877-1113).
- CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-888-322-2115 (TTY: 1-800-877-1113).
- XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-888-322-2115 (TTY: 1-800-877-1113).
- 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-888-322-2115 (TTY: 1-800-877-1113).
- ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-888-322-2115 (TTY: 1-800-877-1113).
- ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-888-322-2115 (TTY: 1-800-877-1113).
- ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-325-2115 (رقم هاتف الصم والبكم: 1-800-877-1113).
- ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-888-322-2115 (TTY: 1-800-877-1113).
- ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဖိ. နမၤနှ် ကျိာ်အတ်မၤစၢၤလၢ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 1-888-322-2115 (TTY: 1-800-877-1113).
- ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-888-322-2115 (ATS: 1-800-877-1113).
- 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다 1-888-322-2115 (TTY: 1-800-877-1113) 번으로 전화해 주십시오.
- ማሳታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፣ ወደ ሚከተለው ቁጥር ይደውሉ 1-888-322-2115 (መስማት ለተሳናቸው: TTY: 1-800-877-1113).
- OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-888-322-2115 (TTY - Telefon za osobe sa oštećenim govorom ili sluhom: 1-800-877-1113).
- ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ ។ 1-888-322-2115 (TTY: 1-800-877-1113).

Finding a Plan for You

This booklet reflects our commitment to providing you with personal and comprehensive care. We want members to get the most out of their health plan and that's why it's important to review all the materials in this booklet and other information on our website.

As an Avera Health Plans member, you will have access to our regional network, which includes:

- The largest health system in South Dakota – Avera Health
- Monument Health
- Many other independent providers

TIP: To see if your provider is in-network, search our online directory. Choose **Find a Provider** under the Resources section at the bottom of the home page.

Finding a Plan for You

Direct vs. Marketplace

Two things about health insurance are certain: filling out online forms can be intimidating and finding a plan you can afford is important.

So, bypass the confusion and come to the experts; Avera Health Plans will help you identify the best health plan for you and/or your family.

We want you to have affordable health benefits and that's why we're available to make it as simple as possible.

- Call us toll-free at 1-888-322-2115
- Visit AveraHealthPlans.com

In Your Neighborhood

When you have questions with enrollment or you're ready to pick a plan, we have licensed agents to assist you, available Monday – Friday, 8 a.m. – 5 p.m. CT.

Sioux Falls

5300 S. Broadband Lane
605-322-4500

When to Enroll

You have two opportunities to enroll for health care coverage throughout the year

1

Open enrollment period

When to enroll

An open enrollment period occurs annually and starts Jan 15 and ends Dec. 15.

Effective date

If enroll between Nov 1 through Dec 31, your plan will Start Jan 1. If you enroll for a plan in January, your plan will start Feb 1.

2

Special enrollment period

Outside open enrollment, you need a qualifying life event to apply for an individual policy. Some examples:

- Marriage
- Loss of other creditable coverage (examples include: loss of job, divorce, turning 26)
- Birth, adoption or placement for adoption
- Court-ordered coverage

Learn more at AveraHealthPlans.com

Effective date

You'll have up to 60 days before or after the life event to enroll. In some situations, you can only enroll after the life event has taken place.

Member ID cards

Outside of open enollment, it typically takes about two weeks after we receive your first month's premium payment to receive your identification cards.

Resources to Help You Choose the Right Plan

Example Summary of Benefits and Coverage	
CO-PAY	$25
COINSURANCE	30%
OUT-OF-POCKET MAXIMUM	$3,500 Individual $7,000 Family
DEDUCTIBLE	$1,500 Individual $3,000 Family

Health insurance can be confusing — here are some resources to help.

The Summary of Benefits and Coverage displays information about a health plan in a simple question-and-answer format. It identifies what your initial costs (co-pay, coinsurance, deductible and out-of-pocket maximums) will be and provides other benefit-related information.

Every health insurance carrier is required to show this information and it is a great tool for you in comparing different carrier plans.

Summary of Benefits and Coverage for all our plans can be found at AveraHealthPlans.com under Shop Plans for Individuals.

Understanding Health Insurance Terms

In-Network/ Participating Provider

A health care facility, practitioner or provider who has a signed agreement with Avera Health Plans to provide services to members.

Primary Care Provider

The first health care provider you should contact for treatment, typically includes family practitioners, internists, OB/GYN providers and pediatricians.

Deductible

What you will pay before your insurance will pay for covered services that aren't covered by co-pay or at 100 percent.

Coinsurance

Money you pay for covered health services, calculated as a percentage, for example, the insurance pays 80 percent and you pay 20 percent of the bill. You pay the coinsurance percentage after reaching your deductible until you reach the out-of-pocket maximum.

Premium

Monthly amount that you pay for your health insurance plan. Premium does not figure into the out-of-pocket maximum.

Co-Pay

A fixed amount (for example, $35), that you pay for a covered health care service, such as a clinic or urgent care visit. Your co-pay can vary by the type of service, and whether you see a primary care provider or specialist.

Out-of-Pocket Maximum

The most you have to pay for covered services in a plan year. After you spend this amount on things such as deductibles, co-pays and coinsurance, Avera Health Plans pays 100 percent of the costs of covered benefits.

Understanding Health Insurance Terms

Breaking Down Your Monthly Premium

If purchasing via the MarketPlace, the premium is the amount you pay each month to be covered by health insurance and it is determined by where you live, how many dependents you cover, and your annual income.

You pay a premium regardless of whether or not you've met your deductible for the year.

If you would like to know your premium amount, you can get an estimate by answering a few questions at AveraHealthPlans.com. If you chose to apply or enroll online, you will be given the exact amount that will appear monthly on your statement.

You can also identify if you are eligible for advance premium tax credits. This is an amount that will be paid by the federal government to your health insurance carrier, reducing the monthly premium payment.

Understanding Your Deductible, Co-Pay and Coinsurance Amounts

The medical deductible amount, co-pays and coinsurance amounts are listed on the Summary of Benefits and Coverage for every plan. You can compare these options to help you select the best plan for your budget. For most Avera plans, we have an in-network and out-of-network deductible that add up separately. After you pay the amounts, we begin to pay benefits for your covered health services as listed on your Summary of Benefits and Coverage.

Digital Resources

Being a member has its digital perks. To provide quick access to your personal health information, we've conveniently created multiple digital resources for members to use.

Member Portal

We have a secure website so you can find the resources you need – when you need them. This easy-to-navigate portal gives you access to the following resources:

- Benefits
- Pharmacy
- Claims/Explanation of Benefits
- Well-being portal
- Provider Directory
- Online premium payment option

AveraChart

AveraChart is a free, secure, easy way for Avera patients to access their health care information, communicate with their care team, and become a more active partner in their own health care.

AveraHealthPlans Mobile App

Find in-network providers, make monthly payments and access your claims and year-to-date balances, all from the convenience of your phone.

Virtual Visits

Avera Health Plans Virtual Visits is an online video visit program designed to conveniently connect you with an Avera provider when you don't have time to go to the clinic. Connect to a provider through your phone, tablet or laptop. **Learn more at AveraHealthPlans.com/VirtualVisits.**

Avera Health Plans provides this service to members at no cost. Some limitations apply.

Navigating Your Health Care Coverage

We want you to make the most of your health coverage every year. Here's our guide to helping you navigate some of the common questions and issues members come across.

Will my physician (provider) be covered with Avera Health Plans?

To see if your current provider is part of our network, review our online provider directory at AveraHealthPlans.com. You can also call our Customer Care Team and speak to one of our service associates or request a printed copy of the provider directory. You can make an appointment with any physician or provider, however, if he or she is not listed in our provider directory, you will pay more.

Providers in our network are located in every South Dakota county and in northwest Iowa, southwest Minnesota and northeast Nebraska. An in-network provider is a physician or licensed health care professional, hospital, facility, institution, agency or pharmacy that has signed a contract with us to provide health services to our members.

Because we have great relationships with our providers, we work together to deliver on the promises to treat everyone and every interaction with the highest level of care to meet your health care needs in efficient and cost-effective ways.

Understand that our provider directory changes weekly as we are adding and updating information to the directory frequently. You will still be responsible for making sure the provider is in your network before you arrive.

What happens if I don't use a participating provider?

We understand that there are times you may require a health service or specialty that is not available in the Avera Health Plans network. In those cases, you are encouraged to call our Customer Care Team and ask for help with care coordination from our Care Management Department.

Some of our plans have an out-of-network benefit that allows you to seek another opinion or care from a non-participating provider. However, you will pay more for health services from a non-participating provider.

* For members who live outside our service area for longer than 90 consecutive days, we contract with expanded regional and national networks so you can continue to receive in-network coverage. For more information, contact our Customer Care Team.

Covered Benefits

Avera Health Plans covers* the essential health benefits and more when seeing an in-network provider, including in-network specialist visits. Benefits included with all our new plans for individuals:

- Outpatient services including physical, occupational and speech therapies and dialysis
- Emergency, ambulatory services and urgent care visits
- Hospitalization services
- Maternity and newborn care includes well baby and child physical exams, routine immunizations, and related laboratory services
- Mental health and substance abuse services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services, radiology and other services for the early detection of disease when ordered by a licensed health care provider
- Preventive and wellness services for routine adult physical exams, (examples include gynecologic exams, mammography and prostate and colorectal cancer screenings) immunizations and related laboratory services
- Chronic disease management
- Pediatric service, including dental and vision care
- Durable medical equipment and related supplies
- Skilled nursing, home health and hospice services

Many of the covered benefits above will apply toward your deductible and coinsurance, or you may be responsible for a co-pay, such as when you visit the doctor's office. Many preventive health services are covered at no cost to you.

Services Not Covered

Avera Health Plans does not cover some services.** Exclusions include any services or supplies that are:

- Not medically necessary
- Not specifically described as covered in the Individual Health Insurance Policy
- In excess of any applicable coverage limits
- Part of a treatment plan for non-covered services (Example: follow-up phases of surgery for cosmetic procedures.)
- If using an out-of-network provider some services are not covered such as: chiropractic, durable medical equipment and preventive.

* Note: this is only an illustrative example of benefits covered. These services may require preauthorization for some benefit plans. The Summary of Benefits and Coverage and your Individual Policy provide a comprehensive explanation of covered services and preauthorization requirements.

**The Summary of Benefits and Coverage and Individual Health Insurance Policy provide a comprehensive explanation of non-covered services. For information regarding these services, please call our Customer Care Team.

Preauthorization

Preauthorization is the notification process when we approve specific drugs, services, supplies and procedures for care and treatment prior to being received. Preauthorization does not guarantee benefits. Your benefits are subject to all conditions of the Individual Health Policy. It is especially important to receive your medical services with an in-network provider or you will pay more going to an out-of-network provider.

Our Preauthorization Process

In most cases, your provider is aware of when a preauthorization is required. You can always contact our Customer Care Team after you become a member to understand when a preauthorization is required.

Steps to receive pharmacy preauthorization:

- Ask your provider to obtain preauthorization before prescribing certain drugs, or
- When you present your prescription at a participating pharmacy, the pharmacist will contact your provider's office to notify them of the preauthorization requirement.

Without preauthorization for specified drugs, you are responsible for paying the entire billed charge. For additional pharmacy management procedures, including pharmaceutical restrictions, coverage of drugs and the exceptions process, visit our website or contact our Customer Care Team.

When should I call before receiving medical services?

You need to have your provider contact us to verify that preauthorized services, supplies or procedures are a covered benefit. If your provider does not obtain a preauthorization, the services will not be covered.

What if my situation is urgent or I'm currently in the hospital?

If your situation is urgent, or you are emergently admitted to the hospital, your provider will contact us so we can begin the preauthorization process. Our Care Management staff will review your case and provide a decision to you and your provider within 24 hours.

What if I want to request in-network benefits for health services from a non-participating provider?

You or your provider may call us to request in-network benefits for health services from a non-participating provider.

Which medical services require preauthorization?

Your provider can access a current list of services requiring preauthorization at AveraHealthPlans.com.

What is the preauthorization process?

Your provider will need to obtain preauthorization for certain services, supplies and procedures. Additional information can be found on our website at AveraHealthPlans.com.

Your provider will send us clinical information relevant to your care. We will review the information and when a decision is made, you and your provider will receive a letter that states our decision.

What if I didn't get a preauthorization before I received services, supplies or procedures?

If your situation is urgent, or if our preauthorization staff is unavailable (such as weekends, holidays or after business hours), we allow post-service authorization. Your provider must contact us no later than two business days after you receive the services, supplies or procedures.

How will I know if my request is approved?

If the drugs, services, supplies or procedures are approved, the letter will list the services that have been authorized. Please read your confirmation carefully so you know which services have been approved. If your request for preauthorization is urgent, meaning a delay could jeopardize your life, health or ability to regain maximum function or would cause severe pain that could not be adequately managed without the requested care or treatment, we will respond within 24 hours.

What happens if my request is not approved?

If the drugs, services, supplies or procedures are denied, you and your provider will receive a letter describing why your request was denied and what policy, protocol, criteria or benefit provision was used to make the decision. Your treating provider has the option to speak with the physician or other appropriate reviewer to discuss the denial decision.

If you are dissatisfied with the denial decision, you or your authorized representative (as designated in writing by you) may file an appeal within 180 days of the denial decision. Your case will be reviewed by a physician of the same or similar specialty as your treating provider. In most cases, you will receive an appeal determination within 30 days of filing the appeal with us. You can initiate this process regardless of whether you already received the drugs, services, supplies or procedures or they're scheduled in the future.

If you are currently in the hospital, you have the right to an expedited appeal and you will receive a determination no later than 72 hours after filing the appeal with us. If your situation is urgent, you also have the option to file an expedited external appeal with your state's division of insurance.

We will notify you and your treating provider of the appeal decision in writing.

The decision includes:

- The titles and qualifying credentials of the person or persons participating in the appeals process
- A statement summarizing your appeal
- The reviewer's decision and the reason for the decision
- The evidence or documentation source, scientific or clinical judgment or plan provision used to make the decision
- Your right to request a second-level review if you are not satisfied with the decision
- Your right to contact your state's division of insurance including the address and telephone number
- A description of any additional material or information necessary to complete the request and an explanation as to why the information is necessary

Please read any letters you receive from us carefully so you know which services have been approved and/or denied. If your request for preauthorization is urgent, meaning a delay could jeopardize your life, health or ability to regain maximum function or would cause severe pain that could not be adequately managed without the requested care or treatment, we will respond within 24 hours.

An Avera Health Plans medical director is available by phone to discuss coverage determinations based on medical necessity with your provider. Utilization management decision-making is based on medical necessity, applicable coverage guidelines, and appropriateness of care and service.

Avera Health Plans does not compensate individuals who conduct utilization review for issuing denials of coverage, nor does it provide financial incentives for utilization management decision-makers to encourage denials of appropriate coverage. Financial incentives for utilization review do not encourage decisions that result in underutilization.

Drug Coverage

The amount you pay for your prescription depends on the drug's tier level and the benefit level associated with your plan, which is shown on your Summary of Benefits and Coverage.

Avera Health Plans offers a pharmacy plan that provides you with more flexibility and cost-savings through co-pays. Most insurance carriers use a coinsurance system when paying for drugs, which requires you to pay 20 to 30 percent out of pocket.

Our list of preferred prescription drugs is referred to as a Drug Formulary. A Drug Formulary contains a wide range of generic and brand name drugs that have been approved by the U.S. Food and Drug Administration. Your physician can use this list to choose medications for you while helping you save the most money.

To find out which drugs are on our Drug Formulary, visit our website and select Find a Drug at the bottom of the page. If you would like a printed copy, contact our Customer Care Team and one will be mailed to you.

What drugs require preauthorization?

Your provider can access a current list of drugs requiring preauthorization at AveraHealthPlans.com.

What if a drug my provider prescribes is not on the drug formulary?

If a drug your provider prescribes is not covered under our drug formulary, you or your provider can request a formulary exception. You can initiate the exceptions process by calling us, going online or having your provider fax a request to us. After we've received a request for a formulary exception, we work with your provider to review your medical records and determine whether or not the exception will be approved. You will receive a letter regarding whether or not your request was approved. If we do not approve your request, we will provide your appeals rights to you.

What if I want to review all Avera Health Plans' pharmacy management procedures?

You can call or email us at Pharmacy@AveraHealthPlans.com to request copies of our pharmacy management procedures. After we receive your request, we will mail copies to you.

Step Therapy

Step therapy uses the most cost-effective and safest drug available for a specific medical condition. To receive step therapy drugs, your provider must prescribe certain drugs before trying others. Step therapy programs require your provider to prescribe step-one drugs before step-two drugs.

How does step therapy work?

Your provider prescribes a step-one drug. Step-one drugs are proven to be safe and effective. If the step-one drug is not effective or causes adverse effects, your provider may prescribe a step-two drug. Step-two drugs may cost more or have an increased risk to you.

What is the step therapy process?

1. The pharmacist enters your prescription information into the claims system.
2. If your drug is a step-one drug, the pharmacist will fill your prescription.
3. If your drug is a step-two drug, the pharmacist will receive a message about the step therapy requirements and contact your provider.

Your provider can:

- Prescribe a step-one drug or
- Fax us to request a step therapy override

If the override is approved, the pharmacy will fill your prescription for the appropriate co-pay. If the override is denied, the provider will need to prescribe a step-one drug.

If you and your provider decide not to go through the override process, your provider can prescribe a step-two drugs and you will pay the full cost of the prescription.

When to call before receiving pharmacy services:

You need to have your provider or pharmacist call us for preauthorization of certain drugs. If you do not, the drug may not be covered.

Protected Health Information

Avera Health Plans must internally use your protected health information in order to conduct our business and provide you with the care and services you are entitled to as a member.

Avera Health Plans may use or disclose information about you in order to facilitate your treatment and/or payment or to a physician, health care provider, third party administrator, insurance company or other appropriate entities, including government and law enforcement agencies without your signed authorization.

Avera Health Plans will use and disclose your protected information as necessary and as permitted by law, including treatment, payment and operations. Such operations include processing claims, coordination of care, business management, accreditation and licensing, quality improvement, enrollment, underwriting, compliance, auditing and other functions related to your health benefit plan.

Under certain limited circumstances, Avera Health Plans may release your protected health information to your plan sponsor.

Avera Health Plans will not use or disclose your protected health information without your written authorization except as described above. You have the right to revoke authorization.

Before the Company discloses medical information for research, the research will have been approved through a process that evaluates the needs of the research project with your need for privacy. The Company may, however, disclose medical information about you to a person who is preparing to conduct research, but no medical information will leave the Company during that person's review of the information.

In the event that you are deemed incompetent or cannot provide authorization, Avera Health Plans requires documented proof of power of attorney or guardianship prior to release of any information. Our legal counsel will review the documentation prior to release of information.

Avera Health Plans must also provide you with a Notice of Privacy Practices upon your enrollment. The Notice of Privacy Practices further defines your rights and remedies concerning the disclosure of your protected health information.

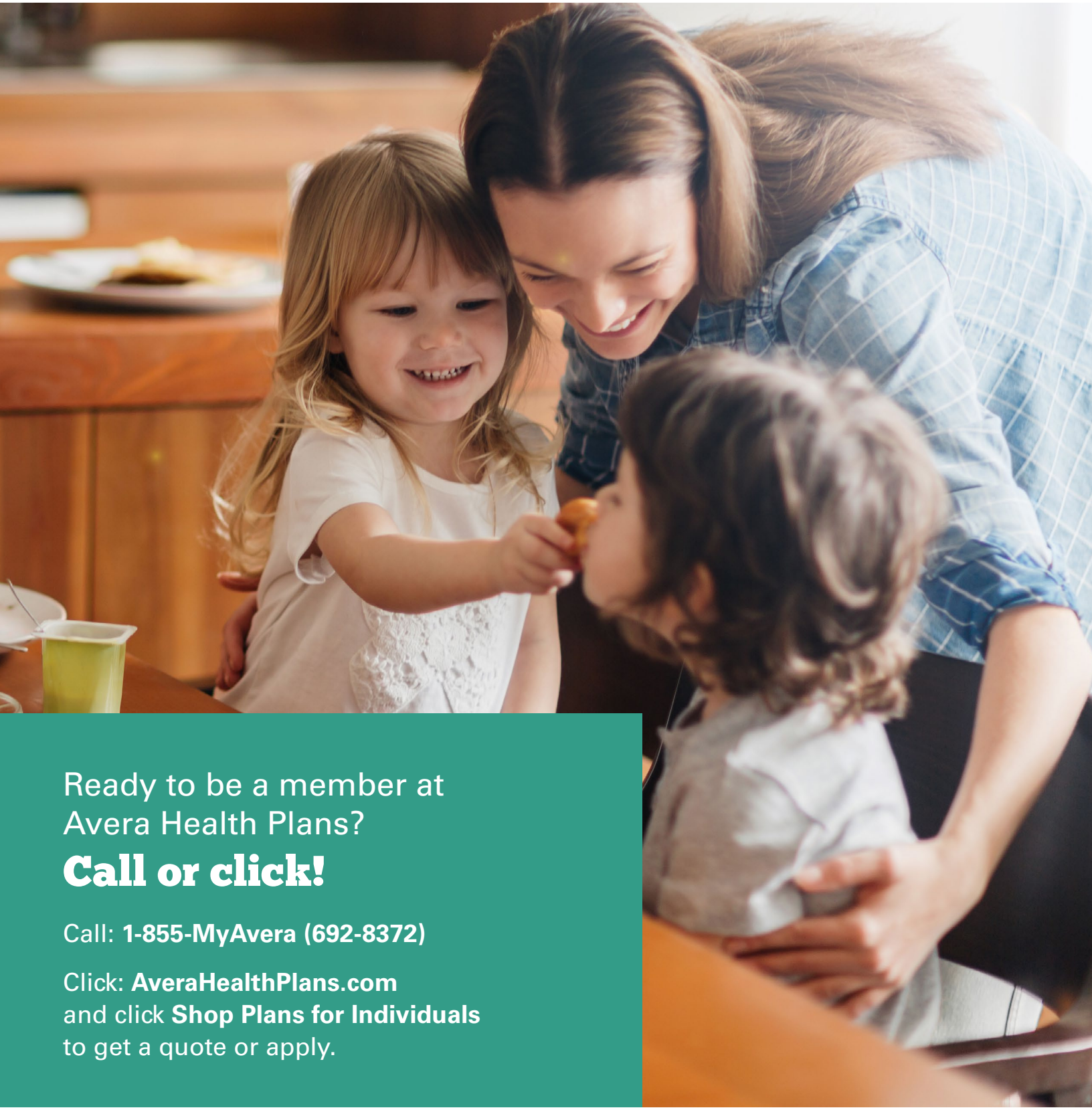
Avera Health Plans maintains oral, physical, electronic and procedural safeguards across the organization that comply with applicable regulatory standards to guard your personal health information.

In addition, Avera Health Plans requires all affiliated parties who maintain your health records to enforce confidentiality policies and procedures within our facilities.

You may review your personal health information and medical records within Avera Health Plans' control by contacting our Customer Care Team to schedule an appointment with the appropriate department representative. You may schedule appointments with physicians, practitioners or other health care providers, from whom you are receiving health care, to review personal health information within their control. To maintain confidentiality in accordance with federal regulations, access to your spouse's health information will be denied unless your spouse provides a written signed document authorizing the release of the information to you. The same rule applies to children covered under your plan who are 18 years old or older.

Avera Health Plans requires that any other person and/or entity receiving information from Avera Health Plans will sign a confidentiality agreement which requires them to abide by and release information in accordance with Avera Health Plans confidentiality policies and procedures. You may receive a copy of the confidentiality policies by contacting our Customer Care Team or going to our website at AveraHealthPlans.com.

Get Started



Ready to be a member at Avera Health Plans?

Call or click!

Call: **1-855-MyAvera (692-8372)**

Click: **AveraHealthPlans.com** and click **Shop Plans for Individuals** to get a quote or apply.

Avera Health Plans